UnitedHealthcare of Florida, Inc.	DEPARTMENT: **Operations**
	LINE OF BUSINESS: **Florida SMMC Plan**
POLICY TITLE: **Claims**	POLICY NUMBER: **OPS**
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REPLACES POLICY# / DATED:	AUTHORIZED BY: **COO**

I. SCOPE:

UnitedHealthcare of Florida, Inc. ("United") Operations and Claims Departments.

II. PURPOSE:

This policy ensures that UnitedHealthcare of Florida, Inc. in conjunction with the United Health Group Claims Department, processes and pays claims in accordance with the guidelines stipulated in the Managed Care Plan Contract.

III. DEFINITION(S):

Terms used in this policy have the same meanings as found in the *State of Florida Agency for Health Care Administration Standard Contract No. FP069*.

IV. POLICY:

1. Claims
   a. The Managed Care Plan shall process claims and pay providers in compliance with the federal and
   State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent. (s. 409.967(2)(j), F.S.)
   b. The Managed Care Plan shall have claims payment performance metrics, including those for quality, accuracy, and timeliness. The Managed Care Plan shall also include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regards to claims processing and claims payment. The Managed Care Plan shall make documentation of such metrics available for Agency review upon request
   c. The Managed Care Plan shall use electronic transmission of claims, transactions, notices, documents, forms, and payments to the greatest extent possible by the Managed Care Plan.

Claims Provisions

a. The Managed Care Plan shall submit an aging claims summary as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

b. For dually eligible enrollees residing in a nursing facility and receiving hospice services, the hospice provider shall bill Medicare for the per diem rate for hospice services.

c. For claims for services:

   a. For all electronically submitted claims for services, the Managed Care Plan shall:

      (1) Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.

      (2) Pursuant to s. 409.982(5), F.S., within ten (10) business days of receipt of nursing facility and hospice clean claims, pay or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

      (3) Within fifteen (15) days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of denial reasons or codes and additional information or documents necessary to process the claim.

      (4) Pay or deny the claim within ninety (90) days after receipt of the non-nursing- facility/non-hospice claim. Failure to pay or deny the claim within one hundred twenty (120) days after receipt of the claim creates an

uncontestable obligation for the Managed Care Plan to pay the claim. (s. 641.3155(3)(e), F.S.)

b. For all non-electronically submitted claims for services, the Managed Care Plan shall:

(1) Within fifteen (15) days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.

(2) Within twenty (20) days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

(3) Pay or deny the claim within one hundred twenty (120) days after receipt of the claim. Failure to pay or deny the claim within one hundred forty (140) days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim.

b. The Plan shall comply with the following standards regarding timely claims processing for all providers:

(1) The Managed Care Plan shall pay fifty percent (50%) of all clean claims submitted within seven (7) days.

(2) The Managed Care Plan shall pay seventy percent (70%) of all clean claims submitted within ten (10) days.

(3) The Managed Care Plan shall pay ninety percent (90%) of all clean claims submitted within twenty (20) days.

c. The Managed Care Plan shall reimburse providers for the delivery of authorized services as described in s. 641.3155, F.S., including but not limited to:

(1) The provider must mail or electronically transfer (submit) the claim to the Managed Care Plan within six (6) months after:

(a) The date of service or discharge from an inpatient setting; or

(b) The date that the non-participating provider was furnished with the correct name and address of the Managed Care Plan, if applicable.

(2) When the Managed Care Plan is the secondary payer and the primary payer is an entity other than Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan within ninety (90) days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook. When the Managed Care Plan is the secondary payer and the primary payer is Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan in accordance with timelines established in the Medicaid Provider General Handbook.

3. **Multipayer Claims Database**

Pursuant to s. 409.967(2)(o), the Managed Care Plan shall contribute all claims data from the Managed Care Plan and its affiliates for services provided to all enrollees and other covered individuals to the Agency's contracted vendor authorized under s. 408.05(3)(c),

V. PROCEDURE:

Providers may submit claims either electronically via www.unitedhealthcareonline.com, WebMD, or another clearinghouse vendor or by sending paper claims to the address listed on the back of the Enrollee's ID card.

Whether submitting claims electronically or by paper, a complete/clean CMS 1500 or UB-92 is required. A complete/clean claim includes the following information; additional information may be required by us for particular types of services or based on particular circumstances or state requirements.

- Patient's name, sex, date of birth and relationship to subscriber.
- Subscriber's employer group name and group number.
- Name, signature, "remit to" address and phone number of physician or provider performing the service, as in your contract document.
- Physician's or provider's federal tax ID number
- Date of service(s), place of service(s) and number of services (units) rendered.
- Current CPT and HCPCS procedure codes with modifiers where appropriate.
- Current ICD diagnostic codes by specific service code to the highest level of specificity.
- Referring physician's name (if applicable)
- Charges per service and total charges.
- Information about other insurance coverage, including job-related, auto or accident information, if available.
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers as well as CPT 99360 (physician standby)
- Attach an anesthesia report for claims submitted with a 23, QS, G8 or G9 modifier.
- Attach a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or "other" revenue codes as well as experimental or reconstructive services.
- Attach nursing notes and treatment plan for claims submitted for home

health care, nursing or skilled nursing services.

- Purchase price for DME rental claims exceeding $500.
- If you need to correct and re-submit a claim, submit a new CMS 1500 or UB-92 indicating the correction being made. Hand corrected claim re-submissions will not be accepted.

Additional information needed for a complete UB-92 form:

- Date and hour of admission and discharge as well as patient status-at-discharge code.
- Type of bill code
- Type of admission (e.g. emergency, urgent, elective, newborn).
- Current revenue code and description.
- Current principal diagnosis code (highest level of specificity).
- Current other diagnosis codes, if applicable (highest level of specificity).
- Attending physician ID
- Bill all outpatient surgeries with the appropriate revenue and CPT code if reimbursed according to ambulatory surgery groupings.
- Provide specific CPT and appropriate revenue code (e.g. laboratory, radiology, diagnostic or therapeutic) for services reimbursed based on a contractual fee maximum.
- Attach an itemized list of services or complete box 45 for physical, occupational or speech therapy services (revenue code 420-449) submitted on a UB-92.
- Attached an itemized statement if submitting a claim that will reach the contracted stop loss.
- Submit claims according to any special billing instructions that may be indicated in your agreement (or letter of agreement).

Pursuant to 42CFR447.45, 42CFR447.46 and Chapter 641, F.S., the Claims Processing Department ensures that:

a) Ninety percent (90%) of clean claims are paid within thirty (30) days from receipt at the Managed Care Plan;
b) Ninety-nine percent (99%) of clean claims are paid within ninety (90) days of receipt a the Managed Care Plan; and
c) All clean claims are paid within twelve (12) months of receipt by the Managed Care Plan.

Claims for Medicare Dual Eligible members are reimbursed pursuant to Section 409.908 F.S.

Authorized services for non-participating providers are reimbursed at:
1) Rate negotiated with the Hospital or physician; or
2) The established Florida Medicaid rate for the hospital or physician (100% of Medicaid).

Claim Adjustments and Appeals may be submitted by calling the Customer Service Department, Provider Services Department or by mailing to the address on the back of the Enrollee's ID Card. They must be submitted within one (1) year of the date of service.

VI. Annual Promulgation of Fee Schedules

For contractually mandated rates and when the Managed Care Plan has entered into provider agreements to reimburse according to the Agency's promulgated fee schedule(s) and/or published rate methodology(ies), the Managed Care Plan shall program its claim processing systems within ninety (90) days following rule promulgation and/or publication by the Agency of revised rate methodologies.

Should a provider submit a claim with Date(s) of Service after the annually approved rates ("Fee Schedule") have been promulgated to the Managed Care Plan, the claim rate may be adjusted to reflect the rate promulgated in the most recent Fee Schedule.

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VII. RELATED POLICIES:

None

VIII. REFERENCES:

None

IX. EXCEPTIONS:

Any exceptions to this policy including attachments must be done in writing and approved by the Chief Executive Officer of UnitedHealthcare of Florida, Inc. The Chief Executive Officer may make exceptions for contracted providers based on contract language that is an exception to this policy.

X. ATTACHMENTS:

None

XI. APPROVED BY:

Travis Garland — **Jan 20, 2021**
Managed Care Plan – Chief Operating Officer — Date

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P&P Revision Control Log

Revision Date	Summary of Revision(s) (Bullets what has changed, Include Page #)	Reason(s) for Revision	Responsible Person	Approved by QMC
8/12/2017	Add IV.n-p to claims to general claims provisions p3 Removed claims and payment reimbursement sections Remove Liquidated Sanctions	Added into Amend 12 of Contract	Travis Garland	

Revision Date	Summary of Revision(s) (Bullets what has changed, Include Page #)	Reason(s) for Revision	Responsible Person	Approved by QMC
11/26/18		Policy update due to new contract	Beverly Carter	

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08/26/2019	N/A	QMC	Aubrey Boucher	
6/26/2020	Add more information about claims performance measures	Review	Aubrey Boucher	
1/20/2021	Added Section: VI. Annual Promulgation of Fee Schedules	Section was added to provide guidance on adjusting promulgated rates	Travis Garland	Jan. 2021
4/22/2021	Edited Section: VI. Annual Promulgation of Fee Schedules	Expanded description of the adjustment period; removed the 90-day window as the only applicable timeline for adjustments	Travis Garland	April 2021